MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08345

50

CERTIFICATE OF DEATH

Reg. Dist. No. 933

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Rural Fruitland, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Salisbury, Md. R.F.D. 1
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Mary L. Adkins

3.(b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female ✓	White	Widow

6.(b) Name of husband or wife: Thomas H. Adkins ✓
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 13, 1887.

8. AGE: Years	Months	Days	If less than one day
59	10	11	..... hrs. ..... min.

9. Birthplace: Wicomico Co., Md. (Town, county, and state)
10. Usual occupation: At Home
11. Industry or business: ✓
FATHER 12. Name: George H. Dixon
13. Birthplace: Somerset Co., Md.
MOTHER 14. Maiden name: Martha E. Kelley
15. Birthplace: Wicomico Co., Md.
16. Informant: Ray L. Adkins
Address: Fruitland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/25/47 (month) (day) (year)
Cemetery or crematory: Glad Park
Location: Glad Park, Md.
18. Funeral director: De Vilbiss & Wilson Co.
Address: Salisbury, Md.
19. 9/25/47 (Date rec'd by registrar) 19..... Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 24, 1947, at 12:48 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 9, 1947 to Sept. 24, 1947 and that I last saw her alive on Sept. 23, 1947

Immediate cause of death	DURATION
Cancer, Breast	2 years
Due to: Metastasis to Liver	
Due to: Jaundice	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: as above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Charles W. Trader, M.D. M. D. or other
Address: Salisbury, Md. Date signed: Sept. 24, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

462

08346

CERTIFICATE OF DEATH

Reg. Dist. No. 233

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 46 years

Hospital, institution, or street address where death occurred: 1407 North Division St.

How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1407 North Division St.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Matilda Askins

3. (b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: E. Sterling Askins

6.(c) If alive, give age: ✓ years

7. Birth date of deceased (mo., day, yr.): August 10, 1862.

8. AGE: Years: 85 | Months: 1 | Days: 11 | If less than one day: ... hrs. ... min.

9. Birthplace: Delmar, Wicomico, Md. (Town, county, and state)

10. Usual occupation: At Home

11. Industry or business: ✓

FATHER — 12. Name: Leonard Hastings

13. Birthplace: Wicomico Co. Md.

MOTHER — 14. Maiden name: Mary J. Mavis

15. Birthplace: Wicomico Co. Md.

16. Informant: Mrs. Grace A. Rogers

Address: 1407 N. Division St., Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9/24/47 (month) (day) (year)

Cemetery or crematory: Parsons

Location: Salisbury, Md.

18. Funeral director: De Vilbiss Parker Co.

Address: Salisbury, Md.

19. 9/24/47 (Date rec'd by registrar) 19..47.. Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 21 1947, at 7.55 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1947 to Sept 21 1947

and that I last saw her alive on Sept 21 1947

	DURATION
Immediate cause of death: Carcinoma of Colon	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Fred A. Brayman M.D. M. D. or other

Address: Salisbury, Md. Date signed: 9/24/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

166

08347

CERTIFICATE OF DEATH

Reg. Diat. No. 933

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Peninsula General Hospital

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Wicomico

City or town
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: Unknown

3.(a) FULL NAME Aegison Sinnwood

3.(b) Social Security Number Don't know

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	C	no

6.(b) Name of husband or wife: no

6.(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.): 1912

8. AGE:

Years	Months	Days	If less than one day
35	4		hrs. min.

9. Birthplace: Norfolk Va.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Same as above

FATHER
12. Name: Willie Aegison
13. Birthplace: Norfolk Va

MOTHER
14. Maiden name: Maggie Claiborne
15. Birthplace: Norfolk Va

16. Informant

Address Norfolk Va

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 15-47 (month) (day) (year)

Cemetery or crematory Oakwood

Location Norfolk Va

18. Funeral director James H. Stewart

Address Salisbury Md

19. 9/12, 1947 H. Reece Johnson Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 1947, at 9:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ——— 19— to ——— 19—

and that I last saw h— alive on ——— 19—

	DURATION
Immediate cause of death: Gun shot wound of abdomen	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

24. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Homicide Date 9/6/47 Hour 7 P.M.

Where did injury occur? near Princess Anne (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Industry

Means of injury Gun shot Injured at work? No

23. SIGNATURE Henry M. Lankford MD

M. D. or other

Address Princess Anne Md Date signed 9/11/47

HENRY M. LANKFORD, M.D.
Public Examiner
Somerset County

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08348

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CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 4 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Delaware County Sussex

City or town Laurel (If outside city or town limits, write RURAL and give nearest town)

Street No. 213 Market St. (If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Bacon, Mrs Lucy Wright

3. (b) Social Security Number None

4. Sex F

5. Color or race White

6.(a) Single, married, widowed, or divorced ~~Married~~ Widowed

6.(b) Name of husband or wife Jennie Bacon

6.(c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) Apr 2 - 1879

8. AGE: Years 68 Months 5 Days 15 If less than one day — hrs. min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business ✓

FATHER 12. Name Isaac J. Wright

13. Birthplace Md.

MOTHER 14. Maiden name Elizabeth Bacon

15. Birthplace Md.

16. Informant Mrs Vernon Owens

Address Laurel Dela.

17. Burial Date thereof Sept 21-47 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Odd Fellows Cemetery

Location Laurel Del

18. Funeral director Jennie S. Minshall

Address Laurel Del.

19. 9/19, 1947 H. Harriet L. Johnson (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 18, 1947, at 12:20 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 21, 1947, to Sept 18, 1947

and that I last saw hER alive on Sept. 18, 1947

	DURATION
Immediate cause of death AC. Cardiac ARREST. (AT OPERATION)	30 MIN.
Due to CHOLECYSTITIS + Cholelithiasis	6 weeks
Due to COMMON BILE DUCT OBSTRUCTION	"
Other conditions LUES, TERTIARY	UNKNOWN.

(Include pregnancy within 3 months of death)

Major findings of operations COMMON DUCT OBSTRUCTION PANCREATITIS CHRONIC Date of op. 9/18/47

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William B. Long M.D. (M.D. or other)

Address 504 N. Division St. Salisbury, Md. Date signed 9/18/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

08349

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County... Wicomico

City or town... Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 years

Hospital, Institution, or street address where death occurred: Before arrival at hospital

How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Wicomico

City or town... Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No.... 613 Park Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war... ✓

3.(a) FULL NAME Byrd, Mr. Otho L.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife ✓ Minnie C. Byrd

6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1883

8. AGE:

Years	Months	Days	If less than one day
64	7	12	...hrs. ...min.

9. Birthplace Pemberville, Wood Co., Ohio (Town, county, and state)

10. Usual occupation Retired

11. Industry or business Letter Union Office Manager

FATHER 12. Name J. Lewis L. Byrd

13. Birthplace Augusta Co., Va.

MOTHER 14. Maiden name Elizabeth Parks

15. Birthplace Augusta Co., Va.

16. Informant Mrs. O. L. Byrd, Salisbury, Md

Address

17. Buried (Burial, cremation, or removal. Which?) Date thereof 9/24/47 (month) (day) (year)

Cemetery or crematory Deaning's

Location Oak Hall, Va.

18. Funeral director Geo. Hill Dayton Co.

Address Salisbury, Md.

19. 9/29/47 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27 19 47, at 7 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ... and that I last saw him alive on ... 19 ...

Immediate cause of death	DURATION
(a) Coronary Thrombosis	Sudden death
Due to (b)	
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. ...

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury... Injured at work?

23. SIGNATURE Dr. Rademaker MD, Deputy Medical Examiner

M. D. or other

Address Salisbury Md Date signed 9/29/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line corrected is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

08350

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 years
Hospital, institution, or street address where death occurred: 710 Maryland Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 710 Maryland Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mary E. Cantwell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Joseph Cantwell
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 21, 1877.

8. AGE:

Years	Months	Days	If less than one day
70	7	25	hrs. min.

9. Birthplace: Wicomico Co. Md.
(Town, county, and state)
10. Usual occupation: At Home
11. Industry or business:
FATHER 12. Name: Noah Cantwell
13. Birthplace: Wicomico Co., Md.
MOTHER 14. Maiden name: Sallie A. Layfield
15. Birthplace: Wicomico Co., Md.
16. Informant: Mildred C. Newton.
Address: 710 Maryland Ave, Salisbury, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/19/47 (month) (day) (year)
Cemetery or crematory: Parsons
Location: Salisbury, Md.
18. Funeral director: P. E. Veit, Jr. Wicomico Co.
Address: Salisbury, Md.
19. 9/19, 1947 (Date received by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 16, 1947, at 6:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 10 1947 to Sept 16 1947 and that I last saw h-er alive on Sept. 16 1947

Immediate cause of death	DURATION
Coronary thrombosis	6 days
Due to: Hypertension	duration
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: James R. Mann M. D. or other
Address: Salisbury Md Date signed: 9/19/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

08351

CERTIFICATE OF DEATH

Reg. Dist. No. 393

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 109 New York Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 109 New York Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John Anthony Collins

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Margaret L. Collins
6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): Feb. 12-1907

8. AGE:

Years	Months	Days	If less than one day
40	7	12	hrs. min.

9. Birthplace: Delmar Delaware (Town, county, and state)
10. Usual occupation: Prop. Filling Station
11. Industry or business:
FATHER 12. Name: William F. Collins
13. Birthplace: Sussex Co. Del.
MOTHER 14. Maiden name: Fannie Jackson
15. Birthplace: Mardela Md
16. Informant: Mrs. Margaret L. Collins
Address: 109 New York Ave. Salisbury Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 27 1947 (month) (day) (year)
Cemetery or crematory: Wicomico Mem. Park
Location: Salisbury Md
18. Funeral director: Hellen & Walter R. Hellen
Address: Salisbury Md.
19. 9/27 1947 Received and filed [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 24 1947, at 7:50 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 24 1947, to Sept 24 1947
and that I last saw h.i.m. alive on Sept 24 1947

Immediate cause of death	DURATION
Coronary Occlusion	
Due to: Hypertension	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Nature of injury: Injured at work?

23. SIGNATURE: John H. Seaman M.D. M. D. or other
Address: 228 Camden Ave. Salisbury, Md. Date signed: Sept 24, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

164c 08352

Reg. Dist. No. 337

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH: Wicomico

County: Wicomico

City or town: Tyaskin

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: R.D. #1,

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Tyaskin

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.D. #1,

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Doris Lee Cox

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Edward B. Cox

6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): April 30 - 1931

8. AGE:

Years	Months	Days	If less than one day
16	4	18	...hrs. ...min.

9. Birthplace: Princetown Md

(Town, county, and state)

10. Usual occupation: Home life

11. Industry or business

FATHER

12. Name: Clarence Fountain

13. Birthplace: Va.

MOTHER

14. Maiden name: Janie Mace

15. Birthplace: Va.

16. Informant: Mr. Edward B. Cox

Address: R.D. #1. Tyaskin Md

17. (Burial, cremation, or removal. Which?) Burial Date thereof: Sept. 21-47 (month) (day) (year)

Cemetery or crematory: Mardela Cem.

Location: Mardela Maryland

18. Funeral director: Holloway & Co. Walter R. Holloway

Address: Salisbury Maryland

19. (Date rec'd by registrar) Sep 21 1947 R. Woolford Walter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 18 - 47 at 1030 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19... to ...19...

and that I last saw deceased alive on ...19...

	DURATION
Immediate cause of death: Bullet wound of heart	Sudden
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of 9/18/47

Where did injury occur? Tyaskin Wicomico Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury: shot thru chest Injured at work? No

23. SIGNATURE: Lee Rademacher MD Deputy Medical Examiner

M. D. or other

Address: Salisbury Md Date signed: 9/20/47

Dr Lowry

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 552

08353

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Fruitland

(If outside city or town limits, write RURAL and give nearest town)

Street No. no

(If rurol, give LOCATION)

2.(a) If veteran, name war no

3.(a) FULL NAME Crisfield Earl.

3.(b) Social Security Number 220-26-2747

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	colored.	Single.

6.(b) Name of husband or wife no

6.(c) If alive, give age no years

7. Birth date of deceased (mo., day, yr.) about 1891

8. AGE: Years	Months	Days	If less than one day
about 56			..... hrs. ..... min.

9. Birthplace Somerset Co
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Same as above

FATHER 12. Name Henry Page Crisfield

13. Birthplace Somerset Co

MOTHER 14. Maiden name Mamie A Pinkard

15. Birthplace Somerset Co

16. Informant Mrs Beatrice Kiah

Address Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 27-47 (month) (day) (year)

Cemetery or crematory Mt Calvary

Location Fruitland Md

18. Funeral director Isaac T Stewart

Address Salisbury Md

19. 9/27/47 (Date rec'd by registrar) H. C. Kaar H. E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24, 1947 at 12 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-23-47 19.. to 9-24-47 19..

and that I last saw him alive on 9-23-47 19..

Immediate cause of death Carcinoma - Ethmoid Bone — DURATION 1 yr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Lee L. Lowry, M.D.
M. D. or other

Address Fruitland Date signed 9 25 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; give the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

53

08354

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Worcester

City or town Berlin (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Annie E. Davis.

3. (b) Social Security Number

4. Sex Female

5. Color or race White

6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife Frank Davis.

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) May 1, 1870

8. AGE: Years 77 Months 4 Days 16 If less than one day ... hrs. ... min.

9. Birthplace Berlin Wor Co. Md. RFD. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Minos Wyatt -

13. Birthplace Berlin Md.

MOTHER 14. Maiden name Emma Powell.

15. Birthplace Berlin Md

16. Informant Mrs. Charles Powell

Address Ocean City Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/18/47 (month) (day) (year)

Cemetery or crematory Evergreen -

Location Berlin Md.

18. Funeral director Anna A. Burbage

Address Berlin Md.

19. 9/23, 19 H.T. Bassett E. Johnson (Date rec'd by registrar) Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17 1947, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8.10 1947, to 8.25 1947

and that I last saw her alive on 8.25, 1947

Immediate cause of death Cardiac insufficiency

Due to Myocardial insufficiency

Due to Arteriosclerosis

Other conditions Squamous cell ca of forehead (Include pregnancy within 3 months of death)

DURATION

Major findings of operations Squamous cell ca of forehead Date of op. 8.15.47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H.W. Brice M. D. or other

Address 504 N. Division St. Date signed 9.17.47

VS A15 9.45.15M

Dr. Yeaman

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

119a

08355

CERTIFICATE OF DEATH

Reg. Diet. No. 939

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 533 Madison st.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For new born infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 533 Madison st.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Ollie Francis Downes

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): March 22-1947

8. AGE: Years | Months: 6 | Days: 3 | If less than one day: ... hrs. ... min.

9. Birthplace: P.G. Hosp. Salisbury Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Ollie Francis Downes
13. Birthplace: R.D. Millsboro, Del.

MOTHER
14. Maiden name: Martha Francis Maddox
15. Birthplace: Salisbury Md

16. Informant: Mrs Ollie F. Downes
Address: 533 Madison st Salisbury Md

17. Burial
(Burial, cremation, or removal. Which?) Date thereof: Sept. 28-1947 (month) (day) (year)
Cemetery or crematory: Wico. Mem. Park
Location: Salisbury Md.

18. Funeral director: Hitchens & Co. Walter R. Holloway
Address: Salisbury Md

19. 9/28/47 (Date rec'd by registrar) 19 Harriet L. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 25th 1947 at 7:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 24, 1947, to Sept 25, 1947
and that I last saw h.[illegible] alive on Sept 25, 1947.

Immediate cause of death	DURATION
Acidosis	2
Dehydration	
Due to: Infections Diarrhea	2 wks
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged stetisticelly.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... injured at work?

23. SIGNATURE: John H. Yeaman M.D.
M. D. or other
Address: 233 Camden Ave. Salisbury, Md. Date signed: Sept 25, 1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173 08356

CERTIFICATE OF DEATH

Reg. Dist. No. 323

1. PLACE OF DEATH:

County: Washington

City or town: Rural, Sandy Hill (Cresaptown)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 (illegible)

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Maryville
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3.(a) FULL NAME: William Michael Duncan

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Catherine C. Owens

6.(c) If alive, give age: 21 years

7. Birth date of deceased (mo., day, yr.): December 9, 1923

8. AGE: Years	Months	Days	If less than one day
23	7	18	hrs. min.

9. Birthplace: New Mexico
(Town, county, and state)

10. Usual occupation: Aviator

11. Industry or business

FATHER — 12. Name: ?

13. Birthplace

MOTHER — 14. Maiden name: ?

15. Birthplace

16. Informant: Mrs. Catherine C. Duncan

Address: 729 Virginia Ave. Cumberland

17. Burial, cremation, or removal. Which? Burial Date thereof: 10/2/47 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery

Location: Cumberland, Maryland

18. Funeral director: R. E. Hill & Mason Co.

Address: Salisbury, Md.

19. 9/29/47 (Date rec'd by registrar) Bessie E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 27, 19 47, at M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..., 19 ... to ..., 19 ...; and that I last saw him alive on September 27, 19 47

Immediate cause of death	DURATION
Crushed chest	sudden
Fractured femur	death
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 9/28/47

Where did injury occur? Wellsburg (City or town) Wisconsin (County) Ind. (State)

Injured at home, farm, industry, public place (where?): Forest

Means of injury: Plane crash Injured at work? No

23. SIGNATURE: L. A. Rademaker, Jr. Deputy Medical Examiner
M. D. or other

Address: Salisbury, Md. Date signed: 9/30/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08357

153

B

Reg. Dist. No. 833

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Del. County Sussex

City or town Millsboro Del.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Evans Mrs. Margaret

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Archie Evans Dec.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1896 10 - 21

8. AGE:

Years	Months	Days	If less than one day
70	10	15	..... hrs. ..... min.

9. Birthplace Del. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name John Hickman

13. Birthplace Del.

MOTHER 14. Maiden name Henrietta Pickman

15. Birthplace Del.

16. Informant Horace Evans

Address Millville Del.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-9-47 (month) (day) (year)

Cemetery or crematory Bethel

Location Ocean View Del.

18. Funeral director Selby H. Watson

Address Pocomoke, Md.

19. 9/10 1947 (Date rec'd by registrar) Harriet E. Johnson Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6 1947 at 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 15 1947 to Sept. 6 1947

and that I last saw h[illegible] alive on Sept. 6 1947

Immediate cause of death Acute Complegia — Duration 3 wks

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results See above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE David J. Gelsinger M.D. M. D. or other

Address 301 N. Division Salisbury Date signed Sept. 6, 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

8358

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 1/7/47

Hospital, institution, or street address where death occurred:
Eastern Shore Tb. Sanatorium

How long in hospital or institution Since 1/7/47

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Somerset

City or town: Crisfield
(If outside city or town limits, write RURAL and give nearest town)

Street No. 23 Walnut St.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME

Evans, Phoebe Lee

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Ernest C. Evans

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 21, 1899

8. AGE: Years	Months	Days	If less than one day
48	0	28	..... hrs. ..... min.

9. Birthplace: Crisfield, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Edward T. Justice

FATHER — 13. Birthplace: ~~Maryland~~ Virginia

MOTHER — 14. Maiden name: Maggie E. Parks

MOTHER — 15. Birthplace: Maryland

16. Informant: self - on admission

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 22/47 (month) (day) (year)

Cemetery or crematory: Summ... Rest

Location: Crisfield Md

18. Funeral director: Ward Bros Crisfield

Address: 306 Main St. Crisfield

19. Sept 20 1947 (Date rec'd by registrar) Harriet L. Phoebus Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 19 1947, at 8:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1947, to Sept. 19 1947 and that I last saw her alive on Sept. 18, 1947

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	1yr - 9 mo.
Due to:	
Due to:	
Other conditions: Diabetes mellitus	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

SIGNATURE: S. T. Bunker M. D. or other

Address: Salisbury, Md. Date signed 9/19/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr. Gilmore

08359

08359

93e

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH: Wicomico

County

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

P.H. Hospt.

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. 203 West Fondon ave

(If rural, give LOCATION)

2.(a) Ll veteran, name war Spanish War

3.(a) FULL NAME Louis Augustine Fischer (alias James Cunningham)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Gertrude Louise Fischer

6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): April 14-1878

8. AGE: Years: 69 Months: 4 Days: 27 If less than one day: ...hrs. ...min.

9. Birthplace: Albany, N.Y. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business:

FATHER — 12. Name: Joseph Fischer

13. Birthplace: Brauch Germany

MOTHER — 14. Maiden name: Anna Pislach

15. Birthplace: Burhaated Germany

16. Informant: Mrs. Gertrude L. Fischer

Address: 203 W. Fondon ave, Salisbury Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Sept. 16-1947 (month) (day) (year)

Cemetery or crematory: Arlington Cem.

Location: Fort Meyer, Virginia

18. Funeral director: Hilling & Co. Walter R. Hilling

Address: Salisbury, Maryland

19. 9/16/47 (Date rec'd by registrar) Margaret L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 11th 1947 at 6.25 P.M.

I HEREBY CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1946 to Sept. 11 1947

and that I last saw him alive on Sept. 11 1947

	DURATION
Immediate cause of death: Congestive Heart Failure	1 year
Due to: Coronary Artery Heart Disease	2 years
Due to: Enterosclerosis of Coronary Arteries	Symptoms 2 yrs.
Other conditions: Pulmonary Emboli	1 week

(Include pregnancy within 3 months of death)

Major findings of operation: — Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE: David J. Gilmore M.D.

Address: 301 N. Division M. D. or other

Salisbury Md Date signed: Sept. 13, 1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47d

08360

CERTIFICATE OF DEATH

Reg. Dist. No. 393

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? (illegible)
Hospital, institution, or street address where death occurred: R.D. #3
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. Co. Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. #3
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Donald Walton Fisher

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 25 1931

8. AGE: Years: 15 | Months: 11 | Days: 3 | If less than one day: hrs. min.

9. Birthplace: Woodbury N.J. (Town, county, and state)
10. Usual occupation: school Boy
11. Industry or business:

FATHER
12. Name: Howard Walton Fisher
13. Birthplace: Clayton N.J.

MOTHER
14. Maiden name: Emma Mae Johnson
15. Birthplace: Bridgeton N.J.

16. Informant: Mrs. Emma Mae Fisher
Address: R.D. #3. Salisbury Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Oct 1-47 (month) (day) (year)
Cemetery or crematory: Cedar Green Cem.
Location: Clayton N.J.

18. Funeral director: Albert J. Mathis
Address: 43 N. Delsea Drive Glassboro N.J.

19. 9/29 (Date rec'd by registrar) 1947 H. Russell Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 28 1947 at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 26, 1947 to Sept 25 1947
and that I last saw him alive on Sept 28 1947.

Immediate cause of death: Osteogenic Sarcoma of Humerus with metastasis to Lungs and Liver. — DURATION: ?

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John H. Foreman M.D. M. D. or other
Address: 233 Lemmon Ave. Salisbury Md. Date signed: Sept 29, 1947

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

938

08361

CERTIFICATE OF DEATH

Reg. Dist. No. 933

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Peninsula General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Allen Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: no
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: Willie Fleming

3.(b) Social Security Number: 262-24-7860

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	a a	Single

6.(b) Name of husband or wife: no
6.(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.): May 3; 1920

8. AGE: Years	Months	Days	If less than one day
27	4	7	hrs. min.

9. Birthplace: Old Field, Ga. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Same as above
FATHER 12. Name: Jessie Fleming
13. Birthplace: Ga
MOTHER 14. Maiden name: Lillie Strong
15. Birthplace: Ga.
16. Informant: Annie an. Byrd
Address: Salisbury Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 17-47 (month) (day) (year)
Cemetery or crematory: Public
Location: Salisbury Md
18. Funeral director: James B. Stewart
Address: Salisbury Md
19. 9/17 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: SEPTEMBER 10, 1947, at 12:20 AM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Medical Examiners Certificate
and that I last saw h... alive on ... 19...
Immediate cause of death: CORONARY THROMBOSIS — DURATION: sudden
Due to: myocarditis — DURATION: years
Due to: — DURATION:
Other conditions: — DURATION:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [illegible], M. D. or other
Address: Salisbury Md Date signed: 9/10/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08362

CERTIFICATE OF DEATH

Reg. Dist. No. 399

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 1/2 hrs

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 16 1/2 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Johnson Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Foskey, Mr Walton (Walton O. Foskey)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Catherine Ann Foskey

6.(c) If alive, give age: 26 years

7. Birth date of deceased (mo., day, yr.): May 14 - 1911

8. AGE: Years: 36 | Months: 3 | Days: 28 | If less than one day: hrs. min.

9. Birthplace: Laurel Delaware (Town, county, and state)

10. Usual occupation: Butcher

11. Industry or business:

FATHER — 12. Name: Thomas Foskey

13. Birthplace: Sussex Co. Del

MOTHER — 14. Maiden name: Fannie King

15. Birthplace: Sussex Co. Del.

16. Informant: Mrs. Catherine Ann Foskey

Address: Johnson St. Salisbury Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Sept. 15-47 (month) (day) (year)

Cemetery or crematory: Wi Co. Mem. Park

Location: Salisbury Md.

18. Funeral director: Holloway & Williams (Walter R. Williams)

Address: Salisbury Md.

19. 9/15/47 (Date rec'd by registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 12 1947, at 10:20 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/7 1947 to 9/12 1947

and that I last saw him alive on 9/12 1947

Immediate cause of death	DURATION
Uremic Pneumonia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Fred R. Graves M.D. M. D. or other

Address: Salisbury, Md. Date signed: 9/15/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Dr. Trader

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

130

08363

Reg. Diat. No. 393

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 101. Zion Street.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 101. Zion Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Jessie Susie Goff

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Samuel Goff
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): June 4- 1918

8. AGE: Years 29 | Months 3 | Days 7 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Dames Quarter Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business: at Home

FATHER
12. Name: Thomas H. Williams
13. Birthplace: Dames Quarter Md.

MOTHER
14. Maiden name: Cora Messick
15. Birthplace: Dames Quarter Md.

16. Informant: Mrs. Cora Williams
Address: 101. Zion, st. Salisbury Md

17. Burial, cremation, or removal. Which?: Burial
Date thereof: Sept. 13 1947 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Maryland.

18. Funeral director: Fleming & Walter R. Fleming
Address: Salisbury Maryland.

19. 9/13/47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 11 1947, at 305 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 11, 1947 to Sept. 11, 1947 and that I last saw h.e.r. alive on Sept. 11, 1947

Immediate cause of death	DURATION
Tuberculosis, Pulmonary	4 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Charles A. Trader, M.D.
M. D. or other
Address: Salisbury, Md. Date signed: Sept. 12, 1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct page is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

08364

CERTIFICATE OF DEATH

Reg. Dist. No. 933

1. PLACE OF DEATH:
County: Wycomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
P. H. Hoyt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wycomico
City or town: Salisbury
(If outside city or town limits write RURAL and give nearest town)
Street No. 205 Center St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Ora Lee Hall

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Bessie Mamie Hall
6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): July 18-1867

8. AGE: Years: 80 | Months: 2 | Days: 8 | If less than one day: hrs. min.

9. Birthplace: Laurel Del. (Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business:

FATHER
12. Name: Philip Hall
13. Birthplace: Sussex Co. Del

MOTHER
14. Maiden name: Mary Wilson
15. Birthplace: Sussex Co. Del

16. Informant: Mrs. Bessie M. Hall
Address: 205 Center St. Salisbury Md

17. (Burial, cremation, or removal. Which?) Buried Date thereof: Sept. 29-1947 (month) (day) (year)
Cemetery or crematory: County Memorial Cemetery
Location: Near Salisbury Md
18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Md.

19. 9/29/47 (Date rec'd by registrar) 19 47 H. Harriet L. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 26- 1947 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 26 1947, to Sept 26 1947 and that I last saw him alive on Sept 26 1947

Immediate cause of death	DURATION
Acute Congestive Heart failure	30 min.
Due to: Coronary Occlusion	30 min.
Due to: Arteriosclerotic Heart disease	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Fred R. Adams M.D. M. D. or other
Address: Salisbury, Md. Date signed: 9/26/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Long on Blue

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170C

08365

CERTIFICATE OF DEATH

Reg. Diat. No. 933

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Tyaskin (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Handy, William M

3.(b) Social Security Number 219-07-3867

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Colored	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 21, 1914

8. AGE: Years	Months	Days	If less than one day
33	1	13	..... hrs. ..... min.

9. Birthplace Tyaskin, Wicomico, Md. (Town, county, and state)

10. Usual occupation Truck Driver

11. Industry or business

FATHER 12. Name George Handy

13. Birthplace Tyaskin, Md.

MOTHER 14. Maiden name Teresa Elsey

15. Birthplace Tyaskin, Md.

16. Informant Mildred Bailey

Address Tyaskin, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/7/47 (month) (day) (year)

Cemetery or crematory Private Cemetery

Location Tyaskin, Md.

18. Funeral director C. S. Messick

Address Bivalve, Md.

19. 9/6 (Date rec'd by registrar) 1947 H. Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 4 1947, at 1:40 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 3 1947 to Sept 4 1947 and that I last saw him alive on Sept 4 1947

Immediate cause of death	DURATION
(1) Fracture skull, Basilar area with post traumatic brain	1 day
Due to (2) Fracture simple, complete, tibia 1/3	1 day
Due to right femur	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None. Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of Sept 3 1947

Where did injury occur? Girdell's (City or town) Worcester (County) Md. (State)

Injured at home, farm, industry, public place (where?) R.R. Crossing

Means of injury Hit by train Injured at work? Driver of car yes

23. SIGNATURE William B. Long M.D.

Address 504 N. Division St. Salisbury, Md. M.D. or other

Date signed Sept 4 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use the correct age if especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Accident report shows that an automobile was involved. 11-3-47

Wi. Bule

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

91

08366

Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury Md (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 years
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. 307 Truitt (If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME Hayes Mrs. Mae C.
3. (b) Social Security Number ✓

4. Sex Female
5. Color or race White
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Charles C. Hayes, Sr.
6.(c) If alive, give age 53 years
7. Birth date of deceased (mo., day, yr.) May 1, 1892.
8. AGE: Years 55 Months 4 Days 14 If less than one day ... hrs. ... min.
9. Birthplace Bristol, Tenn (Town, county, and state)
10. Usual occupation At Home
11. Industry or business ✓
FATHER 12. Name William Crumley
13. Birthplace Tennessee
MOTHER 14. Maiden name Belle Guerlee
15. Birthplace Tennessee
16. Informant Charles C. Hayes, Sr.
Address 307 Truitt St., Salisbury, Md.
17. Burial (Burial, cremation, or removal, Which?) Date thereof 9/18/47 (month) (day) (year)
Cemetery or crematory Tennessee
Location Bristol, Tenn.
18. Funeral director Re Hill & Johnson Co.
Address Salisbury, Md.
19. 9/17, 1947 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15 - 1947, at 2:50 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6 Sept 1947, to 15 Sept 1947
and that I last saw her alive on 15 Sept 1947

Cause	DURATION
Immediate cause of death: Generalized vascular collapse	6 hrs
Due to: Toxic absorption	7 days
Due to: Gangrenous 18 in of lower jejunum (volvulus)	
Other conditions: Thrombosis of portal vein (Include pregnancy within 3 months of death)	

Major findings of operations: Gangrenous lower jejunum Date of op. 9.8.47.
Autopsy results: Thrombosis of portal vein
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work? ...

23. SIGNATURE H. H. Buile M. D. or other
Address 504 N Division St Date signed 9.16.47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45.15M

(I)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1142

08367

Reg. Dist. No. 393

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 7/16/47

Hospital, institution, or street address where death occurred:
Eastern Shore Tb. Sanatorium

How long in hospital or institution? Since 7/16/47

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

Street No. 610 East Church Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: HENRY, Robert Goldsborough

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Maude Henry

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): July 28, 1887

8. AGE: Years	Months	Days	If less than one day
60	1	6	...hrs. ...min.

9. Birthplace: Cambridge, Maryland
(Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business:

FATHER — 12. Name: Robert Goldsborough Henry

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Julia Muse

15. Birthplace: Maryland

16. Informant: Patient at time of admission

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 6. 1947 (month) (day) (year)

Cemetery or crematory: Parsons Cemetery

Location: Salisbury Md.

18. Funeral director: Holloway & Co. Per. Shuttleworth

Address: 520 E. Church St. Salisbury Md.

19. 9/6 (Date rec'd by registrar) 1947 H. L. Bassett D. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 4 1947 at 5:00p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 1947 to Sept 4 1947 and that I last saw him alive on Sept. 4 1947

Immediate cause of death: Lung abscess. — DURATION: Three Years

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: H. H. Hunder M. D. or other

Address: Salisbury, Maryland Date signed: 9/4/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08368

131 b

CERTIFICATE OF DEATH

Reg. Dist. No. 330

1. PLACE OF DEATH:

County Wicomico

City or town Mardela Springs - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

San Domingo

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Mardela Springs - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. San Domingo

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME Retsie M. Hopkins

3. (b) Social Security Number 215-18-4747

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife Noah Hopkins

6.(c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) January 22, 1901

8. AGE:

Years	Months	Days	If less than one day
46	8	4	...hrs. ...min.

9. Birthplace Wicomico County, Maryland (Town, county, and state)

10. Usual occupation Housework

11. Industry or business Home

FATHER

12. Name Thomas Moore

13. Birthplace Wicomico County, Maryland

MOTHER

14. Maiden name Rachael Stanley

15. Birthplace Wicomico County, Maryland

16. Informant Noah Hopkins

Address Mardela Springs, Maryland, R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof September 30, 1947 (month) (day) (year)

Cemetery or crematory San Domingo Cemetery

Location Near Sharptown, Maryland

18. Funeral director J. J. Frampton and Son

Address Federalsburg, Maryland

19. Sept 30 1947 (Date rec'd by registrar) W. H. Robertson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 26 1947, at 3 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Septem ber 24 1947 to Sept. 25th 1947 and that I last saw h.. alive on September 26th 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions Chronic Nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE William E. Purcell M. D. or other

Address Hebron, Md. Date signed Sept. 27-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

08369

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R F D #1
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Baby Boy Humphreys

3.(b) Social Security Number:

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced:

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.):

8. AGE: Years | Months | Days | If less than one day: 10 hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Maurice Franklin Humphreys
13. Birthplace: Salisbury, Md.

MOTHER
14. Maiden name: Flora Beatrice Powell
15. Birthplace: Elmer, Maryland

16. Informant: Mr. Maurice Franklin Humphreys
Address: Salisbury Md #1

17. Cremation
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory: Peninsula General Hospital

Location: Salisbury, Maryland

18. Funeral director: Peninsula General Hospital

Address: Salisbury, Md

19. 9/20/47 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 19, 1947, at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 19, 1947 to Sept. 19, 1947 and that I last saw him alive on Sept. 19, 1947

Immediate cause of death	DURATION
Respiratory Failure	
Due to: Prematurity (26 wks. gestation)	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert R. Flan, M. D. or Other

Address: Salisbury Date signed: 9-19-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46 f

08370

Reg. Dist. No. 335

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Hse
City or town Sharptown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wic
City or town Sharptown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Nahum James

3.(b) Social Security Number

4. Sex: M
5. Color or race: W
6.(a) ~~Single~~, married, ~~widowed, or divorced~~

6.(b) Name of husband or wife: Berkley H James
6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.): Dec 25 — 1869

8. AGE: Years 77 | Months 8 | Days 19 | If less than one day: hrs. min.

9. Birthplace: Bridges-Luxulyan Cornwall England
(Town, county, and state)

10. Usual occupation: Retired quarryman

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden name: "
15. Birthplace: "

16. Informant: William F Wright
Address: Laurel, Del.

17. Burial (Burial, cremation, or removal? Which?) Date thereof 9 17 1947 (month) (day) (year)
Cemetery or crematory Evergreen
Location Sharptown
18. Funeral director: Graton & Boos
Address Sharptown

19. 9-17 1947 (Date rec'd by registrar) Walter E Mann Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 14 1947 at 10P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1947 to Sept 14 1947
and that I last saw him alive on Sept 14 1947

	DURATION
Immediate cause of death: Carcinoma Gall Bladder	
Due to: Perplexed	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W S Wallace M. D. or other
Address Sharptown Md Date signed 9/16/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157a

C8571

CERTIFICATE OF DEATH

Reg. Dist. No. 933

1. PLACE OF DEATH:

County: Wicomico

City or town: Fruitland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Three months

Hospital, institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Fruitland Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.: and

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: Harold Johnson

3. (b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	a a	Single

6.(b) Name of husband or wife: no

6.(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.): Mar 18 1946

8. AGE:

Years	Months	Days	If less than one day
2	6	7	...hrs. ...min.

9. Birthplace: Belleglade Florida (town, county, and state)

10. Usual occupation: no

11. Industry or business: no

FATHER — 12. Name: Thomas Blaitt

FATHER — 13. Birthplace: West Palm Beach

MOTHER — 14. Maiden name: Ivy Johnson

MOTHER — 15. Birthplace: West Palm Beach

18. Informant: Ivy Johnson

Address: Fruitland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 27 47 (month) (day) (year)

Cemetery or crematory: Mt Calvery

Location: Fruitland Md

18. Funeral director: James H Stewart

Address: Salisbury Md

19. 9/27 1947 (Date rec'd by registrar) Harriet O. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 25th 1947, at 10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 16 47 to Sept 25 1947

and that I last saw h... alive on Sept 24 1947

Immediate cause of death	DURATION
Hydrocephalus -	Life
Due to	
Due to	
Other conditions: Bronchitis - Malnutrition	2wks Life -

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Lee L. Lawry, M.D. M. D. or other

Address: Fruitland, Md Date signed: 9-26-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

469 08372

Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico.
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Wicomico.
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. Woodland Av.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Vernon Thomas Kellam

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Married

6.(b) Name of husband or wife Mary Ella Holden
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) April 29 1906

8. AGE: Years	Months	Days	If less than one day
41	4	19	..... hrs. ..... min.

8. Birthplace Kellam, Accomack Virginia
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business Factory.
FATHER 12. Name Alfred Cecil Kellam
13. Birthplace Accomack County, Va
MOTHER 14. Maiden name Maggie Ayres.
15. Birthplace Accomack County, Va
16. Informant Maggie Kellam
Address Woodland Av. Salisbury, Md.
17. Burial Date thereof Sept. 21st 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Redhill Cemetery
Location Kellam, Virginia
18. Funeral director J. Edgar Thomas
Address Accomac, Virginia
19. 9/8/47 1947 Casey C. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 18 1947 at 1:45 A.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept. 17, 1947 to Sept 18 1947
and that I last saw h... alive on Sept. 17, 1947

Immediate cause of death	DURATION
Due to Carcinoma of Head of Pancreas	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE G. H. Lemby MD
M.D. or other
Address Salisbury Md Date signed 9/20/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

la Gilmore

108

08373

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. B 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 5 days - 7 1/2 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Penna. County: Perry
City or town: Andersonburg (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME: Lyons McDonald Merle
3.(b) Social Security Number:

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: ~~Janet M. Bolze~~
6.(c) If alive, give age: 34 years
7. Birth date of deceased (mo., day, yr.): Feb 22, 1913

8. AGE: Years	Months	Days	If less than one day hrs. min.
34	6	20	

9. Birthplace: Andersonburg, Pa (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Farming
FATHER 12. Name: John Lyons
13. Birthplace: Perry Co, Penna.
MOTHER 14. Maiden name: Alice Stope
15. Birthplace: Perry Co Penna
16. Informant: John Lyons
Address: Blain, Penna.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 15, 1947 (month) (day) (year)
Cemetery or crematory: Blain Cemetery
Location: Blain, Penna.
18. Funeral director: Ernest H. Nickel
Address: Loysville, Penna
19. 9/13, 1947 (Date rec'd by registrar) Harriet E. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 12, 1947, at 12 35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 6 1947, to Sept. 12 1947 and that I last saw him alive on Sept. 12 1947

	DURATION
Immediate cause of death: Lobar pneumonia Bilateral	4 days
Due to	
Due to	

Other conditions: Congestion + edema of brain Splenomegaly petechiae of skin + stomach (Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results: See above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: David J. Gilmore M.D. (M. D. or other)
Address: 301 N. Division Salisbury, Md. Date signed: Sept. 12, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46 e BC

08374

Reg. Diat. No. 993

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 Months
Hospital or Institution, or street address where death occurred: 116 Walston ave.,
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County
City or town Baltimore 18 (If outside city or town limits, write RURAL and give nearest town)
Street No. 338 E. University Parkway (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Monnie Louise Maddux

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Elwood Sterling Maddux
6.(c) If alive, give age Dead years
7. Birth date of deceased (mo., day, yr.) March 6-1888

8. AGE: Years 59 Months 6 Days 16 If less than one day hrs. min.

9. Birthplace Cupid Md (Town, county, and state)
10. Usual occupation worker at Dress shops.
11. Industry or business

FATHER
12. Name Charles C. Moore
13. Birthplace Cupid Md.

MOTHER
14. Maiden name Zona Lawson
15. Birthplace Cupid Md.

16. Informant Mrs. J. Edgar Parker
Address 116 Walston ave. Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 24-47 (month) (day) (year)
Cemetery or crematory Asbury Church Cem
Location Cupid Maryland
18. Funeral director Hillman & Walter R. Hillman
Address Salisbury Maryland.

19. 9/24/47 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22nd 1947 at 2:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 11, 1947 to Sept. 22, 1947.
and that I last saw her alive on Sept. 21, 1947.

Immediate cause of death Carcinoma of the Sigmoid — DURATION 1 year

Due to Generalized Metastasis (Carcinomatosis)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Charles W. Trader M.D. M. D. or other
Address Salisbury, Md. Date signed Sept 23, 1947.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

08375

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH:

County Wicomico

City or town Nanticoke
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Fifty years.

Hospital, institution, or street address where death occurred

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Nanticoke
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Sadie Jane Messick

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife Horace J. Messick

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1876

8. AGE: Years	Months	Days	If less than one day
71	—	—	..... hrs. ..... min.

9. Birthplace Wetipquin, Wicomico, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Julius Catlin
13. Birthplace Unknown

MOTHER
14. Maiden name Jane White
15. Birthplace Unknown

16. Informant Mary Darby

Address Nanticoke, Md.

17. Burial Date thereof 9/4/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Turners Cemetery

Location Nanticoke, Md.

18. Funeral director C. S. Messick

Address Bivalve, Md.

19. 9/3 1947 R. Wolford Walter
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2 1947, at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 25 March 1947, to 2 September 1947

and that I last saw h.er alive on 2 September 1947

Immediate cause of death	DURATION
Cardiac Failure	1 mo.
Due to Arteriosclerotic Heart	
Due to Disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Dale H. Sweeders M.D.
M. D. or other

Address Nanticoke Md. Date signed 3 Sept 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

08376

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1860

Reg. Dist. No. 999

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, Institution, or street address where death occurred: Peninsula General Hospital.

How long in hospital or institution? 7 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: New Jersey County: Camden

City or town: Magnolia

(If outside city or town limits, write RURAL and give nearest town)

Street No.: West Madison Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Mezger, Mrs Sarah

3.(b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, (widowed) or divorced
Female.	White	Married

6.(b) Name of husband or wife: Benjamin F Sr.

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 6, 1874.

8. AGE: Years 73 Months 8 Days 7 If less than one day ..... hrs. ..... min.

9. Birthplace: Philadelphia Pa (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Brown

FATHER 13. Birthplace: Philadelphia, Penna.

MOTHER 14. Maiden name: Pat Brown

MOTHER 15. Birthplace

16. Informant: George M. Mezger.

Address: 36 Myrtle Ave., Clayton, Del.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/17/47 (month) (day) (year)

Cemetery or crematory: Harleigh

Location: Camden, New Jersey

18. Funeral director: The Hill & Horsey Co.

Address: Salisbury, Md.

19. 9/16 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-13 1947, at 11 20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h.. alive on ..... 19.....

Immediate cause of death	DURATION
Sepsis, general	1 week
Due to: Decubitus ulcer Infected Surgical wound	2 weeks
Due to: Fractured Right Femur	7-27-47
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Fractured neck of femur Date of op. 7-29-47

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 7-27-47

Where did injury occur? Delmar (City or town) Wicomico (County) Md (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Slipped & fell Injured at work? No

23. SIGNATURE: Postdeath under M D Deputy Med Examiner M. D. or other

Address: Salisbury Md Date signed 9-13-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

08377

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Wetipquin (If outside city or town limits, write RURAL and give nearest town) Md.
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? /

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Somerset
City or town: Crisfield (If outside city or town limits, write RURAL and give nearest town)
Street No.: Somerset Ave., (If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Nelson, Richard Thomas

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife: Theresa T. Nelson
6.(c) If alive, give age: 41 years

7. Birth date of deceased (mo., day, yr.): December 4, 1904

8. AGE: Years	Months	Days	If less than one day
43	9	24	hrs. min.

9. Birthplace: Crisfield, Md. (Town, county, and state)
10. Usual occupation: Seafood Packer
11. Industry or business: Owner

FATHER
12. Name: Harry J. Nelson
13. Birthplace: Crisfield Md.

MOTHER
14. Maiden name: Olivia Riggin
15. Birthplace: Crisfield, Md.

16. Informant: Theresa T. Nelson
Address: Crisfield, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/1/47 (month) (day) (year)
Cemetery or crematory: Asbury Cemetery
Location: Crisfield, Md.

18. Funeral director: Hubbard & Covington
Address: Salisbury Md, Crisfield

19. 9/30/47 (Date rec'd by registrar) Isaac L. Dykes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 28 1947 at 1:15 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 28 1947 to Sept 28 1947
and that I last saw deceased alive on Sept 28 1947

Immediate cause of death	DURATION
Fractured skull	Sudden death
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: No
Date of op.
Autopsy results: No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 9/28/47
Where did injury occur? Wetipquin (City or town) Wicomico (County) Md (State)
Injured at home, farm, industry, public place (where?) Forest
Means of injury: Jumped from plane in almost deep forest Injured at work? No

23. SIGNATURE: J. A. Rademaker M.D.
Deputy Med Exam M. D. or other
Address: Salisbury Md Date signed 9/30/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Evidence for the change of usual residence is shown on G 112 9/15/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

167

08378

CERTIFICATE OF DEATH

Reg. Diat. No. 993

1. PLACE OF DEATH:
County: Wicomico County
City or town: Salisbury Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Don't know
Hospital, Institution, or street address where death occurred: Peninsula Gen. Hospital
How long in hospital or institution? Several Years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico England
City or town: Nassau — Bahama Islands
(If outside city or town limits, write RURAL and give nearest town)
Street No.: no
(If rurul, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: O'Brien, Aden

3.(b) Social Security Number: don't know

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Married

6.(b) Name of husband or wife: Christine Cole
6.(c) If alive, give age: 19 years

7. Birth date of deceased (mo., day, yr.): about 1926

8. AGE: Years: about 21 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Nassau Island Bahamas (Town, county, and state)
10. Usual occupation: Farm Work
11. Industry or business: Same as above
FATHER 12. Name: Unknown
FATHER 13. Birthplace: Unknown
MOTHER 14. Maiden name: Unknown
MOTHER 15. Birthplace: Unknown
16. Informant: James Cole
Address: Morris Labor Camp #11
17. Burial, cremation, or removal. Which?: Burial Date thereof: Sept 4 1947 (month) (day) (year)
Cemetery or crematory: Public
Location: Salisbury Md
18. Funeral director: Jesse H. Stewart
Address: Salisbury Md
19. (Date rec'd by registrar) 9/11 1947 H. Adriel E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 2, 1947 1947 at 12 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h alive on 19

Immediate cause of death: Hemorrhage — DURATION: Sudden death
Due to: Stab wound of aorta & Pulmonary vein — DURATION: 2 hrs
Due to: — DURATION:
Other conditions: — DURATION:
(Include pregnancy within 3 months of death)

Major findings of operations: None — Date of op.
Autopsy results: as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Homicide Date of 9/1/47
Where did injury occur? Salisbury (City or town) Wicomico (County) Md (State)
Injured at home, farm, Industry, public place (where?) Myrtle Club
Means of injury: Stabbed in back Injured at work? No
23. SIGNATURE: Lafayette Anderson MD Deputy Med Examiner M. D. or other
Address: Salisbury, Md Date signed: 9/1/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Grance

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

938

08379

Reg. Dist. No. 393

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH: Wicomico

County

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: R.D. # 4

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.D. # 4.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME James W. Parker

3. (b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widower

6.(b) Name of husband or wife: Sarah Parsons Parker

6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): Sept. 21 1856

8. AGE: Years 90 | Months 11 | Days 21 | If less than one day: hrs. min.

9. Birthplace: Pittsville Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER 12. Name: Minos Parker

13. Birthplace: Pittsville Md.

MOTHER 14. Maiden name: Charlotte Buttingham

15. Birthplace: Pittsville Md.

16. Informant: Mr. Everett Jones

Address R.D. # 4. Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 14-47 (month) (day) (year)

Cemetery or crematory Parker Cem.

Location Near Pittsville Maryland

18. Funeral director: Wilson & Wm. Walter R. Wilson

Address Salisbury Maryland.

19. 9/14 (Date rec'd by registrar) 1947 Margaret L. Wilson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12 1947, at 3 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 1 1947, to Sept 12 1947

and that I last saw h[illegible] alive on Sept 12 1947

Immediate cause of death

Chronic Myocarditis

Due to Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. R. Grance M.D. M. D. or other

Address Salisbury Md. Date signed 9/12/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

08380

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days - 6 hrs.

Hospital, institution, or street address where death occurred:
Peninsula General Hospital

How long in hospital or institution? 2 days - 6 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Parsons Baby Boy Gurney Allen

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	

6.(b) Name of husband or wife: mother Frances Mae Parsons

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 9/8/47 at 2 44 am

8. AGE: Years	Months	Days	If less than one day
2 da. 6 hrs			..... hrs. ..... min.

9. Birthplace: Salisbury, Md. Wicomico Co.
(town, county, and state)

10. Usual occupation: Baby

11. Industry or business

FATHER
12. Name: Parsons, Clarence Williams
13. Birthplace: Salisbury, Md.

MOTHER
14. Maiden name: Butts, Frances Mae
15. Birthplace: Salisbury, Md.

16. Informant: Clarence Parsons, father
Address: Salisbury, Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 9/10/47 (month) (day) (year)

Cemetery or crematory: Peninsula Gen. Hosp.

Location: Salisbury, Md.

18. Funeral director: Peninsula Gen. Hosp.

Address: Salisbury, Md.

19. 9/11 1947 (Date rec'd by registrar) Carrie L. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 10, 1947, at 8 30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/8/47 19.. to 9/10 1947 and that I last saw him alive on 9/9 1947

Immediate cause of death	DURATION
Prematurity 2 Wks Stillborn	2 days
Due to unknown	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None ..... Date of op. .....

Autopsy results: NO.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Thorne Christensen M. D.
M. D. or other

Address: Salisbury, Md. Date signed 9.10.47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct as is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

08381

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

Reg. Dist. No. 393

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury, R.D. 3
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years 5 months
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 1 hour

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury, Md. R.D. 3.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Jim Road
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Marie Le Grande Powell

3. (b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mervie A. Powell
6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Nov. 17, 1883.

8. AGE:

Years	Months	Days	If less than one day
63	10	7	...hrs. ...min.

9. Birthplace: Benton, Tennessee
(Town, county, and state)
10. Usual occupation: Retired Druggist ✓
11. Industry or business:
FATHER 12. Name: Charles C. Powell
13. Birthplace: Tennessee
MOTHER 14. Maiden name: Emma Perkins
15. Birthplace: Tennessee
16. Informant: Mrs. Mervie A. Powell
Address: Salisbury, Md. R.D. 3
17. Burial (Burial, cremation, or removal. Which?), Date thereof: 9/27/47 (month) (day) (year)
Cemetery or crematory: Fairmount
Location: Denver, Colorado.
18. Funeral director: McNeill & Johnson Co.
Address: Salisbury, Md.
19. 9/24/47 (Date rec'd by registrar) 19 47 Harriet J. Johnson Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 24, 1947, at 7:40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19 47 to Sept 24 19 47
and that I last saw him alive on Sept 24 19 47

Immediate cause of death	DURATION
Acute Congestive Heart Failure	3 Hrs
Due to: Coronary Occlusion	3 Hrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Lloyd R. Chapman M.D.
M. D. or other
Address: Salisbury, Md. Date signed: 9/24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

58d 08382

Reg. Dist. No. 33

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cost of age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Worcester

City or town: Salisbury Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? One week

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Newark

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Frances Purnell

3.(b) Social Security Number: Lost

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W.	Married

6.(b) Name of husband or wife: Charles Purnell

6.(c) If alive, give age: 36 years

7. Birth date of deceased (mo., day, yr.): May 10 1912

8. AGE: Years: 35 Months: 4 Days: 1 If less than one day: hrs. min.

9. Birthplace: Berlin, Worcester Co., Md.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: John R. Marshall

13. Birthplace: Snow Hill, Maryland

MOTHER — 14. Maiden name: Malala Bowen

15. Birthplace: Berlin, Maryland

16. Informant: Charles Purnell

Address: Newark, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9-14-'47 (month) (day) (year)

Cemetery or crematory: Evergreen Berlin

Location: Berlin Md.

18. Funeral director: James F. Stewart

Address: Salisbury, Md.

19. 9/13/19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 11 19 47, at 10:16 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 5, 1947 1947, to Sept. 11 19 47

and that I last saw h[illegible] alive on Sept 19

Immediate cause of death	DURATION Symptoms
Congestive Heart Failure	3 weeks
Due to: Acute Rheumatic Carditis	3 weeks
Due to:	
Other conditions: Pericarditis, Acute Pleuritis (Include pregnancy within 3 months of death)	10 days 4 days

Major findings of operations: —

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: David Gilmore M.D.

M. D., or other

Address: 301 N. Division Salisbury, Md. Date signed: Sept. 13, 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

47d 08383

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct name is especially important. Physicians: Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH
County: Wicomico
City or town: Willards
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Main street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)
State: Md. County: Wicomico
City or town: Willards
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Noah Taylor Rayne

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Addie D. Rayne
6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Oct. 9 - 1876

8. AGE: Years: 70 Months: 11 Days: 11 If less than one day: hrs. min.

9. Birthplace: Willard Md ~~Richmond Va~~ (Town, county, and state)

10. Usual occupation: Retired Merchant

11. Industry or business

FATHER
12. Name: Joel Rayne
13. Birthplace: Willards Md.

MOTHER
14. Maiden name: Rosena Baker
15. Birthplace: Huntsville Del.

16. Informant: Mrs. Addie D. Rayne
Address: Willards Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Oct. 1-47 (month) (day) (year)
Cemetery or crematory: New Hope Cem.
Location: near Willards Maryland

18. Funeral director: Holloway & Walter R. Hollaway
Address: Salisbury Maryland.

19. 10/1/47 (Date rec'd by registrar) Bessie C. E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 28th 1947 at 9 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1942 19.. to day of death 19.. and that I last saw him alive on day of death 19..

Immediate cause of death	DURATION
Carcinoma of lungs	5 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statisticaDy.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank R. Lewis M.D.
M. D. or other
Address: Willards Md. Date signed 9-31-47.

(Dr. Imley)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46 f

08384

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Parsonsburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
R.D. #1.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Parsonsburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D. #1.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Ernest Logan Shockley

3.(b) Social Security Number:

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Annie B. Shockley
6.(c) If alive, give age: 63 years
7. Birth date of deceased (mo., day, yr.): Sept. 22 - 1882
8. AGE: Years: 64 Months: 11 Days: 9 If less than one day: hrs. min.
9. Birthplace: Whiton Maryland (Town, county, and state)
10. Usual occupation: Farmer and minister M.P. Church
11. Industry or business:
12. FATHER — Name: John H. Shockley
13. FATHER — Birthplace: Whiton Md.
14. MOTHER — Maiden name: Rosa Ellis
15. MOTHER — Birthplace: Worcester Maryland
16. Informant: Mrs. E. Lester Shockley
Address: R.D. #1. Parsonsburg Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 16-47 (month) (day) (year)
Cemetery or crematory: Wicomico Mem. Park
Location: Salisbury Maryland
18. Funeral director: Gillespie & Walter R. Gillespie
Address: Salisbury Maryland.
19. 9/16/47 (Date rec'd by registrar) Edith C. G. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 13 19 47 2:20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 19 47 to Sept 13 19 47 and that I last saw him alive on Sept 3 19 47

Immediate cause of death	DURATION
Carcinoma Liver	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: Carcinoma of Liver
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?
23. SIGNATURE: Geo. A. Linthicum M. D. or other
Address: Salisbury Md. Date signed: 9-15-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

08385

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 79 years

Hospital, Institution, or street address where death occurred: 1307 N. Division St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No. 1307 N. Division St. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Sarah Ellen Gordy Smith

3.(b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: J. Frank Smith

6.(c) If alive, give age: ✓ years

7. Birth date of deceased (mo., day, yr.): Nov. 18, 1867.

8. AGE:

Years	Months	Days	If less than one day
79	9	20	...hrs. ...min.

9. Birthplace: Wicomico Co., Md. (Town, county, and state)

10. Usual occupation: At Home

11. Industry or business: ✓

FATHER

12. Name: Samuel A. Gordy

13. Birthplace: Wicomico Co., Md.

MOTHER

14. Maiden name: Agnes Rennie Gordy

15. Birthplace: Wicomico Co., Md.

16. Informant: Mrs. Minnie E. Smith

Address: 1307 N. Division St., Salisbury, Md.

17. Burial, cremation, or removal. Which? Burial Date thereof 9/10/47 (month) (day) (year)

Cemetery or crematory: Parsons

Location: Salisbury, Md.

18. Funeral director: J. D. Hill & Sons Co.

Address: Salisbury, Md.

19. (Date rec'd by registrar) 9/10, 1947 C. Harris Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 8, 1947, at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947 to Sept 8 1947 and that I last saw h[illegible] alive on Sept 7 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	6 days
Due to: Hypertension	duration
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Hunter R. Mann M. D. or other

Address: Salisbury Md. Date signed: 9/9/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

08386

CERTIFICATE OF DEATH

Reg. Diat. No. 933

1. PLACE OF DEATH:

County ...Washington...

City or town ...Hagerstown... (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ...

Hospital, Institution, or street address where death occurred: ...

How long in hospital or institution? ...

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State ...Md.... County ...Washington...

City or town ...Smithsburg... (If outside city or town limits, write RURAL and give nearest town)

Street No. ...Main St... (If rural, give LOCATION)

2.(a) If veteran, name war ...✓...

3.(a) FULL NAME Preston Stanley Sterling

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

8.(b) Name of husband or wife ...None...

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Oct. 31, 1928

8. AGE: Years	Months	Days	If less than one day
19	10	26	...hrs. ...min.

9. Birthplace ...Smithsburg... (Town, county, and state)

10. Usual occupation ...Laborer...

11. Industry or business ...Dry Mg Dept Log...

FATHER 12. Name ...James J Sterling...

13. Birthplace ...Md...

MOTHER 14. Maiden name ...Lillian Armstead...

15. Birthplace ...Va...

16. Informant ...James J Sterling... Address ...Smithsburg...

17. ...Burial... (Burial, cremation, or removal. Which?) Date thereof ...Sept. 30/47... (month) (day) (year)

Cemetery or crematory ...Summit Ridge...

Location ...Smithsburg Md...

18. Funeral director ...Howard D. Mullendore... Address ...306 Main St. Hagerstown Md...

19. ...9/29... 19...47... ...Carrie A. Johnson... (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH ...Sept 27... 19...47..., at ...11:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw him alive on ... 19...

Immediate cause of death	DURATION
Broken neck	Sudden
Compound Fracture Rt Femur	Death
Due to ...	
Due to ...	
Other conditions ...	

(Include pregnancy within 3 months of death)

Major findings of operations ...None...

...Date of op. ...

Autopsy results ...No...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ...Accident... Date of ...9/27/47...

Where did injury occur? ...Washington... (City or town) ...Washington... (County) ...Md... (State)

Injured at home, farm, industry, public place (where?) ...Forest...

Means of injury ...Plane fell in tailspin... Injured at work? ...No...

23. SIGNATURE ...Jos Kademenos M.D... M. D. or other

Address ...Hagerstown Md... Date signed ...9/27/47...

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08387

B Reg. Diat. No. 393

105

Dr. Waters

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of Mother)

State New York County New York

City or town New York City

(If outside city or town limits, write RURAL and give nearest town)

Street No. 619 West 163rd St. N.Y.C. 32

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Symons Mr. Bert (Bert Symons)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Ruth A. Symons

6.(c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Oct. 21st 1893

8. AGE: Years 53 | Months 10 | Days 15 | If less than one day ..... hrs. ..... min.

9. Birthplace New York City N.Y. (Town, county, and state)

10. Usual occupation Concessionaire

11. Industry or business Carnival

FATHER

12. Name (Unknown) Symons

13. Birthplace New York N.Y.

MOTHER

14. Maiden name Fannie Cohen

15. Birthplace New York N.Y.

16. Informant Mrs. Ruth A. Symons #32

Address 619 West 163rd St. New York N.Y.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 9-47 (month) (day) (year)

Cemetery or crematory Columbus Ohio

Location Columbus Ohio

18. Funeral director Holloway & C. Walter R. Holloway

Address Salisbury Maryland

19. 9/7/47 (Date rec'd by Registrar) 19 H. Isaacs Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6 1947 at 5:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 4 1947 to Sept 6 1947 and that I last saw him alive on Sept 6 1947

Immediate cause of death	DURATION
Acute Cardiac Dilatation	
Due to Laryngeal Spasm and Edema	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. Wales MD M. D. or other

Address Salisbury Md. Date signed 9/6/47

301 N. Division St.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

08388

CERTIFICATE OF DEATH

Reg. Dist. No. 337

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Wicomico

City or town Bivalve

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Bivalve

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Ernest Asbury Taylor

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	married

6.(b) Name of husband or wife Eva Taylor

6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Sept. 25, 1872

8. AGE: Years	Months	Days	If less than one day
75	11	10	..... hrs. ..... min.

9. Birthplace Tyaskin, Wicomico, Md. (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Joshua Taylor

13. Birthplace unknown

MOTHER 14. Maiden name Mary Ellen Adams

15. Birthplace unknown

16. Informant Eva Taylor

Address Bivalve, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/9/47 (month) (day) (year)

Cemetery or crematory St. Mary's Cemetery

Location Tyaskin, Md.

18. Funeral director C. S. Messicks

Address Bivalve, Md.

19. Sep. 9 1947 R. Woolford Walter Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6 1947, at 7P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 26 March 1947 to 6 September 1947.

and that I last saw h... alive on 6 September 1947.

	DURATION
Immediate cause of death Cerebral Thrombosis	1 month
Due to Arteriosclerotic cardio vascular Disease	2
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Deland Saunders M.D. M. D. or other

Address Crisfield Maryland Date signed Sept 9 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08389

186a

Reg. Dist. No. 333

1. PLACE OF DEATH: Wicomico

County

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: RD #3

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residences of mother)

State: Md. County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No.: RD #3

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Cordelia Jennie Tilghman

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widow

6.(b) Name of husband or wife: William H. Tilghman

6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): Aug. 18 - 1862

8. AGE: Years: 84 Months: 1 Days: 12 If less than one day: hrs. min.

9. Birthplace: RD. Delmar md.

(Town, county, and state)

10. Usual occupation: At Home

11. Industry or business

FATHER 12. Name: William M. Brody

13. Birthplace

MOTHER 14. Maiden name: Hester A Elphant

15. Birthplace: RD. Delmar Md.

16. Informant: Mrs. Georgia M. Phillips

Address: RD #3 Salisbury Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof Oct. 2-47 (month) (day) (year)

Cemetery or crematory: Parsons Cem.

Location: Salisbury Maryland

18. Funeral director: Holloway & C. Walter P. Holloway

Address: Salisbury Md.

19. 10/1/47 (Date rec'd by registrar) 19 W. L. Barnett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 30 - 1947 at 1.20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 20 1947, to Sept. 27 1947

and that I last saw her alive on Sept. 27 1947

Immediate cause of death: Hypostatic Pneumonia

DURATION

Due to: Fracture - left hip. 4 weeks

Patient twisted her leg, ankle & fell while walking in her yard, causing severe pain she fell at entrance to the house.

Due to:

Other conditions: Uremia.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 8/15/47

Where did injury occur? Salisbury (City or town) RD 3 (County) Md. (State)

Injured at home, farm, industry, public place (where?): Home

Nature of injury: Fall Injured at work?

23. SIGNATURE: Dr L Lowry M. D. or other

Address: Fruitland, Md. Date signed: 9-30-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

3414 — 1951 — JB

Reg. Diat. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 1 hr. 3 mins.

2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State: Delaware County: Sussex

City or town: Laurel R.D.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Ward Mr. Clifford Ez

3.(b) Social Security Number: 221-07-0136

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Married

6.(b) Name of husband or wife: Lena Ward

6.(c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): Sept. 20 1912

8. AGE:

Years	Months	Days	If less than one day
35	0	2	hrs. min.

9. Birthplace: Delaware (Town, county, and state)

10. Usual occupation: Fireman on R.R.

11. Industry or business: R.R.

FATHER — 12. Name: William Ward

FATHER — 13. Birthplace: Delaware

MOTHER — 14. Maiden name: Lillian Parsons

MOTHER — 15. Birthplace: Delaware

16. Informant: Lena Ward

Address: Laurel Delaware

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 25 47 (month) (day) (year)

Cemetery or crematory: Old Fireman Cemetery

Location: Laurel Delaware

18. Funeral director: Frederick J. Riordan

Address: Laurel Del.

19. 9/26, 1947 (Date rec'd by registrar) Grace E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 22, 1947 at 1:03 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 22 1947, to Sept 22 1947

and that I last saw h alive on 19

Immediate cause of death	DURATION
Shock	
Due to: Fracture depressed skull & fracture complete cupula left femur	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of Sept 22, 1947

Where did injury occur? Trap Pond (City or town) (County) Delaware (State)

Injured at home, farm, industry, public place (where?) Public place

Means of injury: Injured at work? No

23. SIGNATURE: William B. Fox M.D.

M.D. or other

Address: Division St. Salisbury, Md. Date signed 9/22/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0831 3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day 14 hrs

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 1 day 14 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Berlin (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Farrow, Elsie Louise

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Mar. 13, 1938

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
9	5	23		

9. Birthplace: Berlin Wor Co Md (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: Johnson Wagner

13. Birthplace: Maryland.

MOTHER — 14. Maiden name: Ethel Evans.

15. Birthplace: Berlin Wor Co Md

16. Informant: Mrs Johnson Wagner.

Address: Berlin Md

17. (Burial, cremation, or removal. Which?) Burial Date thereof: 9/5/47 (month) (day) (year)

Cemetery or crematory: Evergreen.

Location: Berlin Md

18. Funeral director: Duncan A. Burbage

Address: Berlin Md

19. 9/12/47 (Date rec'd by registrar) Harriet E. Johnson Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 6 19 47 at 11 20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 4 19 47 to Sept 6 19 47 and that I last saw h. alive on Sept 6, 1947 19

Immediate cause of death	DURATION
Lobar Pneumonia bilateral	3 days
Due to	
Due to	
Other conditions: acute appendicitis, acute mesenteric adenitis, acute	48 hrs

(Include pregnancy within 3 months of death)

Major findings of operation: acute appendicitis & a. mesenteric adenitis. Date of op.

Autopsy results: see above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: William B. Long M.D. M. D. or other

Address: 504 N. Division St. Salisbury, Md. Date signed: 9/6/47

Dr. Imley

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940

08391

CERTIFICATE OF DEATH

Reg. Dist. No. 323

1. PLACE OF DEATH: Wicomico

County

City or town Salisbury

(If outside city or town limits, writes RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 1106 Hanover St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1106 Hanover St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Carl James Williams

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Grace E. Williams

6.(c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Oct. 25- 1887

8. AGE: Years 59 | Months 10 | Days 16 | If less than one day ... hrs. ... min.

9. Birthplace Salisbury Md. (Town, county, and state)

10. Usual occupation Contractor

11. Industry or business Builder

FATHER 12. Name Marion E. Williams

13. Birthplace Allen Md.

MOTHER 14. Maiden name Emma E. Calloway

15. Birthplace Salisbury Md.

16. Informant Mrs. Grace E. Williams

Address 1106 Hanover St. Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 14-1947 (month) (day) (year)

Cemetery or crematory Glad Point Cem

Location Glad Point Md.

18. Funeral director Hillman & Walter R. Hillman

Address Salisbury Md.

19. 9/18/47 (Date rec'd by registrar) 19 47 Harriet E. S. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11 1947 at 9:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1947 to Sept 11 1947

and that I last saw h.i.m. alive on Sept 1 1947

Immediate cause of death Coronary Thrombosis — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas A Imley M. D. or other

Address Salisbury Md. Date signed 9-12-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(I)

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08392

93d

Reg. Diat. No. 333

1. PLACE OF DEATH: Wicomico
County
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: P. H. Hospt.
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 208 E. Locust St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Isaac John Wootten

3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Annie Wootten
6.(c) If alive, give age: 61 years
7. Birth date of deceased (mo., day, yr.): Aug. 3 1879

8. AGE: Years 68 | Months 1 | Days 14 | If less than one day: hrs. min.

9. Birthplace: R.D. Laurel Delaware
(Town, county, and state)
10. Usual occupation: Engineer at Water Dept. City of Salisbury Md.
11. Industry or business:
FATHER 12. Name: Robert J. Wootten
13. Birthplace: R.D. Laurel Del.
MOTHER 14. Maiden name: Rebecca Downs
15. Birthplace: Quantico, Md.
16. Informant: Mrs. Annie Wootten
Address: 208 E. Locust St. Salisbury Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 19 1947 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Maryland
18. Funeral director: Williams & Co. Walter R. Williams
Address: Salisbury Md.
19. 9/18/47 (Date rec'd by registrar) W. T. Barnett D. I. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17 1947 at 10 20 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 12 1947 to Sept 17 1947
and that I last saw h[illegible] alive on Sept 17 1947

	DURATION
Immediate cause of death: Coronary Occlusion	
Due to: Arteriosclerotic Myocarditis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE L. R. Cramer M.D.
M. D. or other
Address Salisbury, Md. Date signed 9/17/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M